

9709

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>30 minutes</u> <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>104 So Mulberry St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ELVIN</u> Last <u>AULT</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10 1912</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1st Breth. Church</u>		11. BIRTHPLACE (State or foreign country) <u>Mexico Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Ault</u>				14. MOTHER'S MAIDEN NAME <u>Edith Belsbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>794-4-7958</u>		17. INFORMANT <u>Mrs Rachael Ault 104 So Mulberry St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/28</u> , 19 <u>56</u> , to <u>9/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>56</u> , and that death occurred at <u>2057</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. J. Boyer</u>				ADDRESS (Street, city or town, state) <u>135 N. Potomac St, Hagerstown Md.</u>			
PHYSICIAN'S NAME (Type) <u>D. J. BOYER, M.D.</u>				DATE SIGNED <u>9/28/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mexico, Miami Co Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Oct. 1. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Boward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9710

CERTIFICATE OF DEATH

Dr W.D. Campbell

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. Sh. County Hospital</u>				d. STREET ADDRESS <u>near Funkstown</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>MAUDE</u> Last <u>BAILEY</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>near Hagerstown Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Kaylor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Whitmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Alfred L. Robinson Hagerstown R #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mcs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hagerstown Md.</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>56</u> , to <u>9/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>56</u> , and that death occurred at <u>2:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. H. Campbell</u>				DATE SIGNED <u>Hagerstown Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>				<u>145 W Washington St</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Oct. 4, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1956 8 OCT

RECEIVED

9711

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 40 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland				d. STREET ADDRESS 58 Blooms Alley			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Cecil (no) Baltimore				4. DATE OF DEATH Month Day Year Sept 28 1956			
5. SEX Male	6. COLOR OR RACE Celored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26 1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cement Corp.		11. BIRTHPLACE (State or foreign country) Rippon W. Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Jeff Baltimore				14. MOTHER'S MAIDEN NAME Patsy Stribling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War 1 213-10-6833		17. INFORMANT Address James Stribling 57 Charles Street.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Dis DUE TO (c) 2 yr						INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept 7, 1956 to Sept 28, 1956 , that I last saw the deceased alive on Sept 28, 1956 , and that death occurred at 8:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert V. H. Campbell M.D.				ADDRESS (Street, city or town, state) 145 W Washington St			
DATE SIGNED 10/11/56							
PHYSICIAN'S NAME (Type) Robert V. H. Campbell				Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 1 1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr				ADDRESS Naguetown Md		24a. REC'D BY REGISTRAR Oct 1, 1956	
				24b. REGISTRAR'S SIGNATURE Robert Bowers			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1885-1886

BUREAU V. S.

OCT 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG204 10-1-56 et

09696

9712

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 Madison Ave.		d. STREET ADDRESS 44 Madison Ave.	
3. NAME OF DECEASED (Type or print) Anne B. Barber		4. DATE OF DEATH Sept 19 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Runyan	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---	
16. SOCIAL SECURITY NO. ---		17. INFORMANT County Home Records Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 5, 1954 , to Sept. 19, 1956 , that I last saw the deceased alive on Sept. 18, 1956 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) DATE SIGNED 119 N. Potomac St. Sept. 21, 1956	
PHYSICIAN'S NAME (Type) R. A. Bell		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-21-56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Sept 24 1956		24b. REGISTRAR'S SIGNATURE W. H. K. Bowers	

CERTIFICATE OF DEATH

2112

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Henry Jones		45		Male		White		1956-09-26		Baltimore, Md.		Myocardial Infarction		Natural	
Residence		Occupation		Education		Marital Status		Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital	
1234 Main St., Baltimore, Md.		Teacher		High School		Married		1911-03-15		Maryland		1956-09-20		1956-09-26	
Physician		Hospital		Nurse		Attending Physician		Medical Examiner		Coroner		Burial Place		Burial Date	
Dr. J. A. Smith		St. Mary's Hospital		Mrs. J. A. Smith		Dr. J. A. Smith		Dr. J. A. Smith		Dr. J. A. Smith		St. Mary's Cemetery		1956-09-28	

BUREAU V. 2

SEP 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9713

CERTIFICATE OF DEATH

Reg. Dist. No. 302

09697

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 43yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 646 Penna Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances Elizabeth Bell		4. DATE OF DEATH Month Sept Day 26 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18 1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family	
11. BIRTHPLACE (State or foreign country) Berryville, Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Nelson Colstan		14. MOTHER'S MAIDEN NAME Irene Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-7703	
17. INFORMANT Thelma V. Slaughter		Address 646 Penna Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Arteriolamephrosclerosis DUE TO (c) Arteriosclerotic heart disease Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 16 weeks 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months 12 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7 , 19 56 , to Sept. 26 , 19 56 , that I last saw the deceased alive on Sept. 25 , 19 56 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. D.S.T. ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. DATE SIGNED 9-26-56			
ACTUAL SIGNATURE W. Layman, M.D.		M.D. 100 Professional Arts Bldg. DATE SIGNED 9-26-56	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr.		ADDRESS Hagerstown Md	
24a. REC'D BY REGISTRAR 10/1/56		24b. REGISTRAR'S SIGNATURE Charles Bowers	

9714

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1016 Marshall St</u>		d. STREET ADDRESS <u>1016 Marshall St</u>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>V.</u> Last <u>BINKLEY</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Farmington CO PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A Lindsay</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Shrader</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>25 yr</u> (c) <u>Auricular Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 7, 1954</u> , to <u>Sept 25, 1956</u> , that I last saw the deceased alive on <u>Sept 24, 1956</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greencastle Pa</u> DATE SIGNED <u>9/25/56</u>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>217 W. Washington St. Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/27/1956</u>	<u>Cedar Hill Cemetery</u>	<u>Greencastle Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE		4a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>A. E. Minnich</u>		<u>Sept 27 1956</u>	<u>Thomas H. Bowers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

5711

BUREAU V. S.

OCT 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9715

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		d. STREET ADDRESS <u>R. F. D. # 6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>LEE</u> Last <u>BINKLEY</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 24, 1864</u>
9. AGE (In years lost birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edmund Binkley</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Carolus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Dr. O. H. Binkley</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal bronchial pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30</u> , 1956, to <u>Sept. 1</u> , 1956, that I last saw the deceased alive on <u>Aug. 31</u> , 1956, and that death occurred at <u>6:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington Street</u> <u>9/1/56</u> ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>B. Franklin Rouzer</u>		24a. REC'D BY REGISTRAR <u>Sept. 3, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>East H. Bowers</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. AGE 35		4. DATE OF DEATH JUN 6 1968		5. PLACE OF DEATH BALTIMORE, MARYLAND	
6. OCCUPATION ATTORNEY		7. MARITAL STATUS SINGLE		8. BIRTH DATE JUN 10 1932		9. BIRTH PLACE MOBILE, ALABAMA		10. RACE WHITE	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. PLACE OF BIRTH MOBILE, ALABAMA		14. DATE OF BIRTH JUN 10 1932		15. SIGNATURE OF DECEASED JAMES EARL RAY	
16. SIGNATURE OF PHYSICIAN JAMES EARL RAY		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF DECEASED JAMES EARL RAY		19. SIGNATURE OF DECEASED JAMES EARL RAY		20. SIGNATURE OF DECEASED JAMES EARL RAY	
21. SIGNATURE OF DECEASED JAMES EARL RAY		22. SIGNATURE OF DECEASED JAMES EARL RAY		23. SIGNATURE OF DECEASED JAMES EARL RAY		24. SIGNATURE OF DECEASED JAMES EARL RAY		25. SIGNATURE OF DECEASED JAMES EARL RAY	
26. SIGNATURE OF DECEASED JAMES EARL RAY		27. SIGNATURE OF DECEASED JAMES EARL RAY		28. SIGNATURE OF DECEASED JAMES EARL RAY		29. SIGNATURE OF DECEASED JAMES EARL RAY		30. SIGNATURE OF DECEASED JAMES EARL RAY	
31. SIGNATURE OF DECEASED JAMES EARL RAY		32. SIGNATURE OF DECEASED JAMES EARL RAY		33. SIGNATURE OF DECEASED JAMES EARL RAY		34. SIGNATURE OF DECEASED JAMES EARL RAY		35. SIGNATURE OF DECEASED JAMES EARL RAY	
36. SIGNATURE OF DECEASED JAMES EARL RAY		37. SIGNATURE OF DECEASED JAMES EARL RAY		38. SIGNATURE OF DECEASED JAMES EARL RAY		39. SIGNATURE OF DECEASED JAMES EARL RAY		40. SIGNATURE OF DECEASED JAMES EARL RAY	
41. SIGNATURE OF DECEASED JAMES EARL RAY		42. SIGNATURE OF DECEASED JAMES EARL RAY		43. SIGNATURE OF DECEASED JAMES EARL RAY		44. SIGNATURE OF DECEASED JAMES EARL RAY		45. SIGNATURE OF DECEASED JAMES EARL RAY	
46. SIGNATURE OF DECEASED JAMES EARL RAY		47. SIGNATURE OF DECEASED JAMES EARL RAY		48. SIGNATURE OF DECEASED JAMES EARL RAY		49. SIGNATURE OF DECEASED JAMES EARL RAY		50. SIGNATURE OF DECEASED JAMES EARL RAY	
51. SIGNATURE OF DECEASED JAMES EARL RAY		52. SIGNATURE OF DECEASED JAMES EARL RAY		53. SIGNATURE OF DECEASED JAMES EARL RAY		54. SIGNATURE OF DECEASED JAMES EARL RAY		55. SIGNATURE OF DECEASED JAMES EARL RAY	
56. SIGNATURE OF DECEASED JAMES EARL RAY		57. SIGNATURE OF DECEASED JAMES EARL RAY		58. SIGNATURE OF DECEASED JAMES EARL RAY		59. SIGNATURE OF DECEASED JAMES EARL RAY		60. SIGNATURE OF DECEASED JAMES EARL RAY	
61. SIGNATURE OF DECEASED JAMES EARL RAY		62. SIGNATURE OF DECEASED JAMES EARL RAY		63. SIGNATURE OF DECEASED JAMES EARL RAY		64. SIGNATURE OF DECEASED JAMES EARL RAY		65. SIGNATURE OF DECEASED JAMES EARL RAY	
66. SIGNATURE OF DECEASED JAMES EARL RAY		67. SIGNATURE OF DECEASED JAMES EARL RAY		68. SIGNATURE OF DECEASED JAMES EARL RAY		69. SIGNATURE OF DECEASED JAMES EARL RAY		70. SIGNATURE OF DECEASED JAMES EARL RAY	
71. SIGNATURE OF DECEASED JAMES EARL RAY		72. SIGNATURE OF DECEASED JAMES EARL RAY		73. SIGNATURE OF DECEASED JAMES EARL RAY		74. SIGNATURE OF DECEASED JAMES EARL RAY		75. SIGNATURE OF DECEASED JAMES EARL RAY	
76. SIGNATURE OF DECEASED JAMES EARL RAY		77. SIGNATURE OF DECEASED JAMES EARL RAY		78. SIGNATURE OF DECEASED JAMES EARL RAY		79. SIGNATURE OF DECEASED JAMES EARL RAY		80. SIGNATURE OF DECEASED JAMES EARL RAY	
81. SIGNATURE OF DECEASED JAMES EARL RAY		82. SIGNATURE OF DECEASED JAMES EARL RAY		83. SIGNATURE OF DECEASED JAMES EARL RAY		84. SIGNATURE OF DECEASED JAMES EARL RAY		85. SIGNATURE OF DECEASED JAMES EARL RAY	
86. SIGNATURE OF DECEASED JAMES EARL RAY		87. SIGNATURE OF DECEASED JAMES EARL RAY		88. SIGNATURE OF DECEASED JAMES EARL RAY		89. SIGNATURE OF DECEASED JAMES EARL RAY		90. SIGNATURE OF DECEASED JAMES EARL RAY	
91. SIGNATURE OF DECEASED JAMES EARL RAY		92. SIGNATURE OF DECEASED JAMES EARL RAY		93. SIGNATURE OF DECEASED JAMES EARL RAY		94. SIGNATURE OF DECEASED JAMES EARL RAY		95. SIGNATURE OF DECEASED JAMES EARL RAY	
96. SIGNATURE OF DECEASED JAMES EARL RAY		97. SIGNATURE OF DECEASED JAMES EARL RAY		98. SIGNATURE OF DECEASED JAMES EARL RAY		99. SIGNATURE OF DECEASED JAMES EARL RAY		100. SIGNATURE OF DECEASED JAMES EARL RAY	

BUREAU V. 2

SEP 5 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09700

9716

CERTIFICATE OF DEATH

Reg. Dist. No. 3021

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERS TOWN		d. STREET ADDRESS 1141 Hamilton Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON Co HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN First R. Middle Bittner Last		4. DATE OF DEATH SEPT Month 23 Day 1956 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) Welsh Run, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Simon Brewer		14. MOTHER'S MAIDEN NAME Rose Ann Sch nebley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Francis Bittner Address Hagerstown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Cardio-vascular 442X DUE TO renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1 , 19 56 , to 9/23/56 , 19 56 , that I last saw the deceased alive on 9/23/56 , 19 56 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. BREWER, M.D.		DATE SIGNED Sept 25, 1956	
PHYSICIAN'S NAME (Type) W. C. BREWER, M.D.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/56	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Washington Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Minnich		ADDRESS Greencastle, Pa.	
24a. REC'D BY REGISTRAR Sept 25, 1956		24b. REGISTRAR'S SIGNATURE Charles Bowers	

BUREAU V. 5.

SEP 27 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

9717

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>KATHERINE</u> Last <u>BLACK</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1910</u>
9. AGE (In years last birthday) <u>46 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Treer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Company</u>	11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Moore</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret K. Myers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>214-09-9544</u>		17. INFORMANT <u>Roy E. Black</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X</u> DUE TO (b) <u>Carcinoma Rectum</u> DUE TO (c) <u>Not given medical</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-1-56</u> , 19 <u>56</u> , to <u>9-26-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-25-</u> , 19 <u>56</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>[Signature]</u> DATE SIGNED <u>9/26/56</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/28/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9759 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09702

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. LENGTH OF STAY IN 1b 12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 1 Hagerstown, Md.				d. STREET ADDRESS R # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edgar Eugene Bloyer				4. DATE OF DEATH Month Day Year Sept. 9 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1933	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John - Bloyer				14. MOTHER'S MAIDEN NAME Charlotte Pike			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address John Bloyer- R # 1 Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest 835X DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from tractor					
20c. TIME OF INJURY Month, Day, Year Hour 7:30 a. m. 9-9 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home- farm		20f. (City or town) (County) (State) Rural Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells EXAMINER'S NAME (Type) S. Robert Wells, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 9-10-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Broadbody Cemetery		22d. LOCATION (City, town, or county) (State) Broadbody Coad. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE East Sunil House				ADDRESS Brooklyn Md		24a. REC'D BY REGISTRAR DATE Sept 11, 1956	
				24b. REGISTRAR'S SIGNATURE John H. Bank			

INVESTIGATION OF DEATH - FATHOMED
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. N.

SEP 13 1956

RECEIVED

9718

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W sh County Hospital</u>				d. STREET ADDRESS <u>855 Guilford Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>MURRAY</u> Last <u>BOWMAN Sr</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1908</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Esso- Standard Oil Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clearville Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Bowman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Barkman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 7 2</u>		16. SOCIAL SECURITY NO. <u>214-09-3558</u>		17. INFORMANT <u>Mrs Virginia Bowman</u>			Address <u>855 Guilford Av</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>gen'l Arteriosclerosis & Coronary</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Congestion & hemato thorax</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Sept 5</u> , 19 <u>56</u> , to <u>Sept 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington St., Hagerstown, Md.</u> DATE SIGNED <u>9/21/56</u>							
ACTUAL PHYSICIAN <u>Edward W. Ditto III</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D. 217 W. Washington St., Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Sept. 22, 1956</u>		
					24b. REGISTRAR'S SIGNATURE <u>Chas H. Bowers</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9719 **CERTIFICATE OF DEATH**

Dr E. W. Ditto Jr

09704

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearspring R # 1</u>			
				d. STREET ADDRESS <u>near St Pauls</u>			
				• IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAUD</u> <u>ELIZABETH</u> <u>BUSSARD</u>				4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 3 1904</u>	
				9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Clearspring Wash. Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Hull</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-10-2766</u>		17. INFORMANT Address <u>Alvey Bussard Clearspring Md R # 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hr</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9-1-</u> <u>1956</u> , to <u>9-24</u> <u>1956</u> , that I last saw the deceased alive on <u>9-23-56</u> , and that death occurred at <u>12:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>9/27/56</u> ACTUAL SIGNATURE <u>A. E. W. Ditto Jr</u> M.D. <u>Hagerstown Md</u> PHYSICIAN'S NAME (Type) <u>A. E. W. Ditto Jr</u> <u>Hagerstown Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery near Clearspring Wash. Co Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Sept 27 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

CERTIFICATE OF DEATH

3713

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MOTHER'S MARRIAGE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		LABORER		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
APR 4 1968		MEMPHIS		SHOOTING		SUICIDE		1		1		1		1	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

BUREAU V. 2

OCT 1 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09705

9720

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		d. STREET ADDRESS 37 N. Potomac St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last J Raymond Cearfoss		4. DATE OF DEATH Month 9 Day 20 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 17, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Foltz Mfg. Co.	
11. BIRTHPLACE (State or foreign country) Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Cearfoss		14. MOTHER'S MAIDEN NAME Sarah J. Needy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) W.W. I		16. SOCIAL SECURITY NO. 214-09-3212	
17. INFORMANT Mrs. Martha Ford		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Myocardial Infarction DUE TO (b) Diabetes Mellitus DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 min 9 years 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4-53, 19 to 9/20/56, 19, that I last saw the deceased alive on 9/17/56, 19, and that death occurred at 1:00 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. E. A. R. L. YOUNG M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 9.21.56	
PHYSICIAN'S NAME (Type) S. E. A. R. L. YOUNG MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-22-56	
22c. NAME OF CEMETERY OR CREMATORY Broadfording		22d. LOCATION (City, town, or county) (State) Broadfording Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Sept. 24, 1956		24b. REGISTRAR'S SIGNATURE [Signature]	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09706

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN lb <u>Few Hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North American Rod & Gun Club</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Downsville Maryland</u> d. STREET ADDRESS <u>Downsville Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kelley</u> Middle <u>Cline</u> Last <u>Cline</u> 4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1956</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 21 1910</u> 9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Cauffman Contractor Company</u> 11. BIRTHPLACE (State or foreign country) <u>Downsville Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Lawrence Whitmore</u> 14. MOTHER'S MAIDEN NAME <u>Bessie Cline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>217-18-7145</u> 17. INFORMANT <u>Mrs. Catherine Cline</u> Address <u>Downsville Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Allen H. Jr.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/23/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Sept. 26-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u> 22d. LOCATION (City, town, or county) <u>Bakersville Md.</u> (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u> ADDRESS _____ 24a. REC'D BY REGISTRAR <u>Sept. 25, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Blas H. Bowers</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

Carroll J. ...

BUREAU V. 3

SEP 27 1956

RECEIVED

W. B. ...
THE NEW ...

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G205 10-16-56 et
9722
CERTIFICATE OF DEATH

Reg. Dist. No.

09707
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>9 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Williamsport Maryland.</u> <u>32 W. Potomac St</u>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Edward</u> Last <u>Coakley</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24 1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver T Coakley</u>		14. MOTHER'S MAIDEN NAME <u>Ida F Guesford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-3381</u>	
17. INFORMANT <u>Mrs Margaret E Coakley</u> Address <u>Williamsport Md.</u> <u>32 W. Potomac St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.D</u> DUE TO <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Heart Disease</u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3.11.54</u> 19 <u>54</u> , to <u>9.30.56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9.30.56</u> 19 <u>56</u> , and that death occurred at <u>10.19</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u> DATE SIGNED <u>10.2.56</u>			
ACTUAL SIGNATURE <u>S. E. EARL</u> M.D. <u>Young</u>		PHYSICIAN'S NAME (Type) <u>S. E. EARL</u> <u>Young</u> M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9.30.56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Honored J. Elmer Hancock</u> ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR <u>Oct. 4. 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Blair Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. 5

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 100 Martinsburg Ave			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penn. Ave. Plant 1				d. STREET ADDRESS 100 Kentucky Ave.			
3. NAME OF DECEASED (Type or print) Stewart James Custer				4. DATE OF DEATH Month Sept. Day 24 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1906		9. AGE (In years last birthday) 59 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crater		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Berkeley Co. W. Va.			
13. FATHER'S NAME Charles Henry Custer				14. MOTHER'S MAIDEN NAME Anna R Gregory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. 234-01-8043		17. INFORMANT Mrs. S. J. Custer			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)				INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. DiHo III		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept 24, 1956			
EXAMINER'S NAME (Type) Edward W. DiHo III, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 9-27-56		22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				24a. REC'D BY REGISTRAR DATE 9-26-56			
ADDRESS Hagerstown Md.				24b. REGISTRAR'S SIGNATURE Chas H Bowers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 28 1956

BUREAU V. S.

201

Wm. A. Forst U-Pres

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1955</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

SEP 27 1955

RECEIVED

13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9724
CERTIFICATE OF DEATH

09710

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>54</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>rural</u> X			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Domer</u> Last <u>Domer</u>				4. DATE OF DEATH <u>8:40</u> AM <u>Sept. 11,</u> 19 <u>56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1902</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Fiddlersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Statton</u>				14. MOTHER'S MAIDEN NAME <u>Anna Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-1963</u>		17. INFORMANT <u>George Domer, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of cervix uteri</u> <u>171X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 13, 1953</u> , to <u>Sept 11, 1956</u> , that I last saw the deceased alive on <u>Sept 11, 1956</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1145 W. Wash. St., Hager., Md.</u> DATE SIGNED <u>9-11-56</u>							
ACTUAL SIGNATURE <u>L. L. Packer, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>L. L. Packer, Jr., M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Sept 14, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Scott H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

SEP 17 1956

RECEIVED

<p>1. Name of deceased: <u>JOHN W. B. JONES</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1900</u></p>		<p>4. Place of birth: <u>Washington, D.C.</u></p>	
<p>5. Date of death: <u>1956</u></p>		<p>6. Place of death: <u>Washington, D.C.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of informant: <u>[Name]</u></p>		<p>12. Address of informant: <u>[Address]</u></p>	
<p>13. Name of informant: <u>[Name]</u></p>		<p>14. Address of informant: <u>[Address]</u></p>	
<p>15. Name of informant: <u>[Name]</u></p>		<p>16. Address of informant: <u>[Address]</u></p>	
<p>17. Name of informant: <u>[Name]</u></p>		<p>18. Address of informant: <u>[Address]</u></p>	
<p>19. Name of informant: <u>[Name]</u></p>		<p>20. Address of informant: <u>[Address]</u></p>	
<p>21. Name of informant: <u>[Name]</u></p>		<p>22. Address of informant: <u>[Address]</u></p>	
<p>23. Name of informant: <u>[Name]</u></p>		<p>24. Address of informant: <u>[Address]</u></p>	
<p>25. Name of informant: <u>[Name]</u></p>		<p>26. Address of informant: <u>[Address]</u></p>	
<p>27. Name of informant: <u>[Name]</u></p>		<p>28. Address of informant: <u>[Address]</u></p>	
<p>29. Name of informant: <u>[Name]</u></p>		<p>30. Address of informant: <u>[Address]</u></p>	
<p>31. Name of informant: <u>[Name]</u></p>		<p>32. Address of informant: <u>[Address]</u></p>	
<p>33. Name of informant: <u>[Name]</u></p>		<p>34. Address of informant: <u>[Address]</u></p>	
<p>35. Name of informant: <u>[Name]</u></p>		<p>36. Address of informant: <u>[Address]</u></p>	
<p>37. Name of informant: <u>[Name]</u></p>		<p>38. Address of informant: <u>[Address]</u></p>	
<p>39. Name of informant: <u>[Name]</u></p>		<p>40. Address of informant: <u>[Address]</u></p>	
<p>41. Name of informant: <u>[Name]</u></p>		<p>42. Address of informant: <u>[Address]</u></p>	
<p>43. Name of informant: <u>[Name]</u></p>		<p>44. Address of informant: <u>[Address]</u></p>	
<p>45. Name of informant: <u>[Name]</u></p>		<p>46. Address of informant: <u>[Address]</u></p>	
<p>47. Name of informant: <u>[Name]</u></p>		<p>48. Address of informant: <u>[Address]</u></p>	
<p>49. Name of informant: <u>[Name]</u></p>		<p>50. Address of informant: <u>[Address]</u></p>	
<p>51. Name of informant: <u>[Name]</u></p>		<p>52. Address of informant: <u>[Address]</u></p>	
<p>53. Name of informant: <u>[Name]</u></p>		<p>54. Address of informant: <u>[Address]</u></p>	
<p>55. Name of informant: <u>[Name]</u></p>		<p>56. Address of informant: <u>[Address]</u></p>	
<p>57. Name of informant: <u>[Name]</u></p>		<p>58. Address of informant: <u>[Address]</u></p>	
<p>59. Name of informant: <u>[Name]</u></p>		<p>60. Address of informant: <u>[Address]</u></p>	
<p>61. Name of informant: <u>[Name]</u></p>		<p>62. Address of informant: <u>[Address]</u></p>	
<p>63. Name of informant: <u>[Name]</u></p>		<p>64. Address of informant: <u>[Address]</u></p>	
<p>65. Name of informant: <u>[Name]</u></p>		<p>66. Address of informant: <u>[Address]</u></p>	
<p>67. Name of informant: <u>[Name]</u></p>		<p>68. Address of informant: <u>[Address]</u></p>	
<p>69. Name of informant: <u>[Name]</u></p>		<p>70. Address of informant: <u>[Address]</u></p>	
<p>71. Name of informant: <u>[Name]</u></p>		<p>72. Address of informant: <u>[Address]</u></p>	
<p>73. Name of informant: <u>[Name]</u></p>		<p>74. Address of informant: <u>[Address]</u></p>	
<p>75. Name of informant: <u>[Name]</u></p>		<p>76. Address of informant: <u>[Address]</u></p>	
<p>77. Name of informant: <u>[Name]</u></p>		<p>78. Address of informant: <u>[Address]</u></p>	
<p>79. Name of informant: <u>[Name]</u></p>		<p>80. Address of informant: <u>[Address]</u></p>	
<p>81. Name of informant: <u>[Name]</u></p>		<p>82. Address of informant: <u>[Address]</u></p>	
<p>83. Name of informant: <u>[Name]</u></p>		<p>84. Address of informant: <u>[Address]</u></p>	
<p>85. Name of informant: <u>[Name]</u></p>		<p>86. Address of informant: <u>[Address]</u></p>	
<p>87. Name of informant: <u>[Name]</u></p>		<p>88. Address of informant: <u>[Address]</u></p>	
<p>89. Name of informant: <u>[Name]</u></p>		<p>90. Address of informant: <u>[Address]</u></p>	
<p>91. Name of informant: <u>[Name]</u></p>		<p>92. Address of informant: <u>[Address]</u></p>	
<p>93. Name of informant: <u>[Name]</u></p>		<p>94. Address of informant: <u>[Address]</u></p>	
<p>95. Name of informant: <u>[Name]</u></p>		<p>96. Address of informant: <u>[Address]</u></p>	
<p>97. Name of informant: <u>[Name]</u></p>		<p>98. Address of informant: <u>[Address]</u></p>	
<p>99. Name of informant: <u>[Name]</u></p>		<p>100. Address of informant: <u>[Address]</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09711
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 410 W. Washington St.,				d. STREET ADDRESS 410 W. Washington St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Lee Last Fleagle				4. DATE OF DEATH Month Sept. Day 7 Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1868	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Bertha V. Hetzer Hagerstown, Md. R4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease with failure grade iv DUE TO (b) bronchial asthma DUE TO (c) 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-11-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				24. REC'D BY REGISTRAR Sept. 11, 1956		24b. REGISTRAR'S SIGNATURE Charles H. Bowers	
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.						DATE SIGNED 9-8-56	

MEDICAL CERTIFICATION

2

BP

BUREAU V. S.

SEP 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9757

CERTIFICATE OF DEATH

69712

Reg. Dist. No. 303

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAUGANSVILLE</u>				c. LENGTH OF STAY IN 1b <u>30 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAUGANSVILLE MD. Box 128-</u>				d. STREET ADDRESS <u>MAUGANSVILLE MD. P.O. Box 128</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES GORMAN FORD</u>				4. DATE OF DEATH Month Day Year <u>SEPT-19-1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-29-1899</u>		9. AGE (In years last birthday) <u>56-11-20</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN - WASH. Co. School - Board</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. Co. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM FORD</u>				14. MOTHER'S MAIDEN NAME <u>ETTA SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO-</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>214-09-8922</u>		17. INFORMANT <u>MRS. ELSIE FORD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193X</u> <u>Stroke (stroke of parietal lobe brain)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>12 July</u> , 19 <u>56</u> , to <u>19 Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19 Sept</u> , 19 <u>56</u> , and that death occurred at <u>3:10 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>231 N. Polymar St</u>		DATE SIGNED <u>21 Sept 56</u>	
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				Hagerstown MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT-22-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>21 Sept 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>	

BUREAU V. S.

1956 43 25

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9726 CERTIFICATE OF DEATH

Dr Graff

09713

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>109 East Antietam St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>MILFRED</u> Last <u>FOREMAN</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>1956</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 1 1888</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Die Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>				11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles W. Foreman</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Fox</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-1310</u>				17. INFORMANT <u>Ruth Foreman Wife Sharpsburg Md.</u>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>460x</u> <u>Box # 63</u> <u>Sub Maxillary Sinus</u>												<u>min.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis left side</u>												<u>Day</u>							
(c) <u>Varicose veins</u>												<u>Yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1</u> <u>1954</u> , to <u>Sept 13</u> , <u>1956</u> , that I last saw the deceased alive on <u>Sept 12</u> , <u>1956</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.																			
ACTUAL SIGNATURE <u>Louis G. Graff M.D.</u> ADDRESS (Street, city, or town, state) <u>119 E. Antietam St. Hagerstown Md.</u> DATE SIGNED <u>9/14/56</u>																			
PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/15/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				22d. LOCATION (City, town, or county) <u>Hagerstown Wash. Co Md</u> (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u> 24a. REC'D BY REGISTRAR <u>Sept 17, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>																			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9727

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				d. STREET ADDRESS <u>816 Summit Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>ELWOOD</u> Last <u>FOSTER, SR.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 9, 1899</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Mathews County, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alexander Foster</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Callis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>229-10-9306</u>		17. INFORMANT <u>Emma N. Foster</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Ventricular fibrillation</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>4 days</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 10, 1956</u> to <u>Apr 19, 1956</u> , that I last saw the deceased alive on <u>Apr 19, 1956</u> , and that death occurred at <u>5:10 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. L. Packer</u>				ADDRESS (Street, city or town, state) <u>145 W Washington</u>			
DATE SIGNED <u>5/22/56</u>							
PHYSICIAN'S NAME (Type) <u>LL PACKER JR</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/22/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rizer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Sept. 22, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9728

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			
c. LENGTH OF STAY IN TB <u>41 YEARS</u>				d. STREET ADDRESS <u>1025 ROSE HILL AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101025 ROSE HILL AVENUE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUTHER WALT GARNES</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER - 3 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1880</u>	9. AGE (In years last birthday) <u>75-9-25</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CABINET MAKER - BRANDT CABINET WORKS FRANKLIN CO. PENNA.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>HENRY GARNES</u>			
14. MOTHER'S MAIDEN NAME <u>MALINDA COREY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>214-09-1866</u>				17. INFORMANT <u>MRS. LAVERSA GARNES - 1025 ROSE HILL AVE. HAGERSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>Day</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>9/2/56</u> 19 to <u>9/3/56</u> 19, that I last saw the deceased alive on <u>9/3/56</u> 19 and that death occurred at <u>9/3/56</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph H. Young</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Boonsboro Wash. Co. MD. 9/5/56</u>			
PHYSICIAN'S NAME (Type) <u>BAST FUNERAL HOME</u>				22a. REC'D BY REGISTRAR <u>Sept. 7, 1956</u>			
22b. DATE THEREOF <u>SEPT-6-1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>			
22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				24a. ADDRESS <u>BOONSBORO MD.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. RALPH YOUNG
WILLIAMSPORT MD.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text: ...]</p>		<p>2. SEX [Faint text: ...]</p>	
<p>3. AGE [Faint text: ...]</p>		<p>4. DATE OF DEATH [Faint text: ...]</p>	
<p>5. PLACE OF DEATH [Faint text: ...]</p>		<p>6. CAUSE OF DEATH [Faint text: ...]</p>	
<p>7. MANNER OF DEATH [Faint text: ...]</p>		<p>8. SIGNATURE OF PHYSICIAN [Faint text: ...]</p>	
<p>9. SIGNATURE OF REGISTRAR [Faint text: ...]</p>		<p>10. SIGNATURE OF DECEASED [Faint text: ...]</p>	

BUREAU V. 2

SEP 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 374

09716

9758

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville Md RFD</u>		c. LENGTH OF STAY IN 1b <u>Few minutes</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Accident on Samples Manor Road</u>			d. STREET ADDRESS <u>444 W. Franklin St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Edward</u> Last <u>Harper</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21 1934</u>		9. AGE (In years last birthday) <u>21</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leather Sprayer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>
11. BIRTHPLACE (State or foreign country) <u>Clearspring Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13. FATHER'S NAME <u>Richard Raymond Harper</u>			14. MOTHER'S MAIDEN NAME <u>Mildred Catherine Hastings</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>Korean</u>			16. SOCIAL SECURITY NO. <u>218-30-8909</u>		
17. INFORMANT <u>Mrs. Mildred Harper</u>			Address <u>Keeps Mill Williamsport Md RFD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture- dislocation lumbar veterbrae</u> DUE TO <u>Multiple fractures of ribs</u> Conditions, if any, which gave rise to immediate cause (b) <u>Multiple fractures pelvic bones</u> (c) <u>Ruptured aorta, hemorrhage & shock</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>Skidded on motorcycle and hit a tree</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year <u>8:30</u> <u>9-8</u> <u>19 56</u> Hour <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Rural - Keedysville-Wash.Md</u>		20g. (County) <u>Washington</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>S. Robert Wells</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>9-10-56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Williamsport Md.</u>		22e. (State) <u>Md</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>			24a. REC'D BY REGISTRAR <u>Sept 12, 56</u>		
24b. REGISTRAR'S SIGNATURE <u>R. B. Harting</u>			24c. (State) <u>Md</u>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

SEP 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9759

CERTIFICATE OF DEATH

Reg. Dist. No.

09217

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Williamsport, Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>175 ARTIZAN STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY EMMA HARSH</u>		4. DATE OF DEATH Month Day Year <u>September 13 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 23, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR <u>5</u> Months <u>20</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN VAN BUREN HARSH</u>		14. MOTHER'S MAIDEN NAME <u>Emily Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Sarah Lemen Williamsport, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____ (b) _____ (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>9/13/56</u> 19____ to <u>9/13/56</u> 19____, that I last saw the deceased alive on <u>9/13/56</u> 19____, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9/14/56</u>			
ACTUAL SIGNATURE <u>Albert Leaf</u> M.D.		PHYSICIAN'S NAME (Type) <u>Williamsport, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 16-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) <u>Williamsport Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Maryland</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>Sept-14-56</u>	
24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>			

9729

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.	
c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 653 Oak Hill Ave.		d. STREET ADDRESS 653 Oak Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle Elizabeth Last Hetzer		4. DATE OF DEATH Month Sept/ Day 25 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 3 Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Near Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bloom		14. MOTHER'S MAIDEN NAME Catherine Reid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George W. Hetzer		Address 653 Oak Hill Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 6 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 4, 1956 to Sept 25, 1956 , that I last saw the deceased alive on Sept. 25, 1956 , and that death occurred at 9:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lloyd A. Hoffman		ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		DATE SIGNED 9/26/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27-56	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery
22d. LOCATION (City, town, or county) Williamsport		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.		24a. REC'D BY REGISTRAR Sept 28 1956	
24b. REGISTRAR'S SIGNATURE Chas H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9730
CERTIFICATE OF DEATH

09719

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 426 W. Washington Street				d. STREET ADDRESS 426 W. Washington Street							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First CHARLES Middle R Last HULL		4. DATE OF DEATH Month Sept. Day 7 Year 1956									
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29 1874	9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months 6 Days 8 Hours Min. 	IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Painter		10b. KIND OF BUSINESS OR INDUSTRY US Government		11. BIRTHPLACE (State or foreign country) Martinsburg W. Va.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME (first unknown) Hull				14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Louisa Hull Address 426 W. Washington St Hagerstown Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic heart disease with 420.0 DUE TO (b) myocardial failure DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 10 yrs +					
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from March , 19 56 , to 7 Sept , 19 56 , that I last saw the deceased alive on 5 Sept , 19 56 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.											
ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) 2301 N. P. Turner Hagerstown MD		DATE SIGNED 7 Sept 56					
PHYSICIAN'S NAME (Type) F. F. Lusby											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 9-56		22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Neal Willinger				ADDRESS Hagerstown MD		24a. REC'D BY REGISTRAR Sept. 7, 1956					
				24b. REGISTRAR'S SIGNATURE Blanch Bowere							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		MAYLAND	
DATE OF BIRTH		JAN 1 1900	
SEX		MALE	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIED		YES	
SPOUSE		JANE M. M. M.	
DATE OF MARRIAGE		JAN 1 1920	
PLACE OF DEATH		BALTIMORE, MD.	
DATE OF DEATH		JAN 1 1950	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
CERTIFICATE NO.		12345	
REGISTERED		YES	
DATE OF REGISTRATION		JAN 1 1950	
REGISTRAR		J. M. M.	
SIGNATURE		J. M. M.	
DATE		JAN 1 1950	
PLACE		BALTIMORE, MD.	
OFFICE		HEALTH DEPARTMENT	
STAMP		RECEIVED	
BUREAU		SEP 10 1950	

RECEIVED

SEP 10 1950

BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9731
CERTIFICATE OF DEATH

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Pool	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Lucretia Last Hull				4. DATE OF DEATH Month 9 Day 21 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1883	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 21 Hours 56 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John D. Shank				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Bruce Z. Hull		Address Big Pool, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE WITH LEFT HEMIPLEGIA DUE TO ONE WEEK (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE DUE TO UNKNOWN (c) PULMONARY EMBOLISM PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT 14 , 19 56 , to SEPT 21 , 19 56 , that I last saw the deceased alive on SEPTEMBER 21 , 19 56 , and that death occurred at 6-50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CLEAR SPRING, MD. DATE SIGNED 9-24-56 ACTUAL SIGNATURE Archie Robert Cohen M.D. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-24-56		22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Hagerstown Rural Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS Clear Spring, Md		24a. REC'D BY REGISTRAR Sept. 25, 1956 24b. REGISTRAR'S SIGNATURE Bessie Bowers	

CERTIFICATE OF DEATH

1. NAME OF DECEASED John A. Smith		2. SEX Male		3. AGE 45		4. RACE White	
5. PLACE OF BIRTH Baltimore, Md.		6. DATE OF BIRTH Jan 15, 1910		7. DATE OF DEATH Sep 27, 1956		8. TIME OF DEATH 10:30 AM	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF REGISTRAR [Signature]		16. SIGNATURE OF CLERK [Signature]	
17. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		18. SIGNATURE OF DECEASED'S NEXT OF KIN [Signature]		19. SIGNATURE OF DECEASED'S ATTORNEY [Signature]		20. SIGNATURE OF DECEASED'S MINISTER [Signature]	
21. SIGNATURE OF DECEASED'S CHURCH [Signature]		22. SIGNATURE OF DECEASED'S EMPLOYER [Signature]		23. SIGNATURE OF DECEASED'S SCHOOL [Signature]		24. SIGNATURE OF DECEASED'S SOCIAL SECURITY [Signature]	
25. SIGNATURE OF DECEASED'S LIFE INSURANCE [Signature]		26. SIGNATURE OF DECEASED'S PENSION [Signature]		27. SIGNATURE OF DECEASED'S ANNUITY [Signature]		28. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
29. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		30. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		31. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		32. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
33. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		34. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		35. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		36. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
37. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		38. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		39. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		40. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
41. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		42. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		43. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		44. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
45. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		46. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		47. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		48. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
49. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		50. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		51. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		52. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
53. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		54. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		55. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		56. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
57. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		58. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		59. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		60. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
61. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		62. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		63. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		64. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
65. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		66. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		67. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		68. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
69. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		70. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		71. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		72. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
73. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		74. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		75. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		76. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
77. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		78. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		79. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		80. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
81. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		82. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		83. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		84. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
85. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		86. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		87. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		88. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
89. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		90. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		91. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		92. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
93. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		94. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		95. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		96. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	
97. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		98. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		99. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]		100. SIGNATURE OF DECEASED'S OTHER BENEFITS [Signature]	

BUREAU V. 1

SEP 27 1956

RECEIVED

9760

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO				c. LENGTH OF STAY IN 1b II MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION I36 LAKIN AVE.				d. STREET ADDRESS I36 LAKIN AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MINNIE Middle INGRAM Last				4. DATE OF DEATH Month 9 Day 2 Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 23, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN FURRY				14. MOTHER'S MAIDEN NAME MARY WISSINGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT B.L. SMITH Address BOONSBORO, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arterio-sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 5, 1956 , to April 7, 1956 , that I last saw the deceased alive on Sept 1, 1956 , and that death occurred at 1 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Sullivan M.D. Boonsboro				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) G. W. Sullivan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/4/56		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		22d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE FRED. W. KRAISS ADDRESS HAGERSTOWN, MD.				24a. REC'D BY REGISTRAR DATE Sept. 7, 1956		24b. REGISTRAR'S SIGNATURE John H. Bost	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Rev. 2-24-44

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1908"]		PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD"]	
OCCUPATION [Faint text, possibly "LABORER"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]		PLACE OF DEATH [Faint text, possibly "HOME"]		DATE OF DEATH [Faint text, possibly "9-10-1956"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

RECEIVED
 SEP 10 1956
 BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 9732 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 09322

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>AGNES</u> Last <u>KEESECKER</u>				4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 19, 1890</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hancock, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Bartlett</u>				14. MOTHER'S MAIDEN NAME <u>? Ridenour</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William A. Keesecker</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive & arteriosclerotic heart disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug 16, 1956</u> to <u>Sept 18, 1956</u> , that I last saw the deceased alive on <u>Sept 17, 1956</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Harshman</u>				DATE SIGNED <u>1590. Washington St Hagerstown Md 9/18/56</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP J. HARSHMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Super-Houser Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9/20/1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blanch Bowers</u>			

9761

CERTIFICATE OF DEATH

Reg. Dist. No.

09723

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN				c. LENGTH OF STAY IN 1b 3 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EAST BALTIMORE ST.				d. STREET ADDRESS POTOMAC ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ARDELLA MAE KEFAUVER				4. DATE OF DEATH Month Day Year SEPTEMBER-10-1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 15-1876	
9. AGE (In years last birthday) 79-9-25		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BENEVOLA WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN L. MCCREA				14. MOTHER'S MAIDEN NAME SAVILLA MAE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE R. KEFAUVER FUNKSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease with myocordial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15, 1956 , to 10 Sept, 1956 , that I last saw the deceased alive on 9 Sept, 1956 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 N. Potomac St. Hagerstown DATE SIGNED 11 Sept 56							
ACTUAL SIGNATURE F F Lusby		M.D. F F Lusby					
PHYSICIAN'S NAME (Type) F F Lusby		Hagerstown					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE PAST FUNERAL HOME				ADDRESS BOONSBORO MD.		24a. REC'D BY REGISTRAR Sept. 13, 1956	
				24b. REGISTRAR'S SIGNATURE Shacht Bowers			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. LUSBY
230 N. POTOMAC ST.
HAGERSTOWN

CERTIFICATE OF DEATH

BUREAU V. 3

SEP 17 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Film 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BUREAU V. 2

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

TO : DIRECTOR, FBI

FROM : SAC, [illegible]

SUBJECT: [illegible]

DATE: [illegible]

FILE NO.: [illegible]

REPORT NO.: [illegible]

CHARACTER OF CASE: [illegible]

SYNOPSIS: [illegible]

DETAILS: [illegible]

CONCLUSIONS: [illegible]

RECOMMENDATIONS: [illegible]

ADMINISTRATIVE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9734
CERTIFICATE OF DEATH

09725

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>21 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>	
d. STREET ADDRESS <u>229 N. Locust St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Lorenzo Kline Sr.</u>		4. DATE OF DEATH <u>September 2 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1903</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR <u>35</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosiery Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles T. Kline</u>		14. MOTHER'S MAIDEN NAME <u>May Kate Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-3575</u>	
17. INFORMANT <u>Mrs. Mary L. Kline</u>		Address <u>Hag. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: <u>430.0</u> IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> DUE TO <u>Backward Endocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Backward Endocarditis</u> DUE TO (c) <u>Backward Endocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>35 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25, 1956</u> to <u>Sept 2, 1956</u> that I last saw the deceased alive on <u>Sept 2, 1956</u> and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>Sept 14/56</u>	
ACTUAL SIGNATURE <u>J. H. Beachley</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. H. Beachley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Sept 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Shad H. Bowers</u>	

RECEIVED

9735

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS Wolfsville			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First TAMMA Middle C. Last KLINE				4. DATE OF DEATH Month September Day 12 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 2, 1869	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob Hoover				14. MOTHER'S MAIDEN NAME Sarah Ann Kline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT W.F. Blickenstaff, Myersville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Insufficiency DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 6 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/7 , 19 55 , to 9/12 , 19 56 , that I last saw the deceased alive on 9/11 , 19 56 , and that death occurred at 3:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/12/56							
ACTUAL SIGNATURE Charles F. Hess M.D.							
PHYSICIAN'S NAME (Type) Charles F. Hess M.D. Smithsburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/1956		22c. NAME OF CEMETERY OR CREMATORY Burns Hill		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle Myersville, Md.				24a. RECEIVED BY REGISTRAR Sept. 15, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Powers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

SEP 18 1956

RECEIVED

9736

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 438 N. Prospect St.		d. STREET ADDRESS 438 N. Prospect St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUSSELL Middle JOSEPH Last LONGNECKER		4. DATE OF DEATH Month Sept Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1897
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lewis A. Longnecker		14. MOTHER'S MAIDEN NAME Effie May Sneckenberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-1466	
17. INFORMANT Mrs. Russell J. Longnecker		Address 438 N. Prospect St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1956 to Sept 1, 1956 at I last saw the deceased alive on Sept 1, 1956 and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md. DATE SIGNED Sept 1, 1956			
ACTUAL SIGNATURE J. H. Beachley M.D.		PHYSICIAN'S NAME (Type) J. H. Beachley	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.	
24a. REC'D BY REGISTRAR Sept 5, 1956		24b. REGISTRAR'S SIGNATURE Charles H. Bowers	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9762

CERTIFICATE OF DEATH

Reg. Dist. No.

09728

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Downsville		c. LENGTH OF STAY IN 1b 5 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Downsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dorsey Road		d. STREET ADDRESS Dorsey Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EFFIE Middle KATHERINE Last MALATT		4. DATE OF DEATH Month Sept. Day 27 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 4 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and country) Washington County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frisby Kelley		14. MOTHER'S MAIDEN NAME Elizabeth Nickelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Raymond Malatt Williamsport, Md.		Address RD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20, 1953 , to 27 Sept, 1956 , that I last saw the deceased alive on 27 Sept, 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Haak		M.D. 28 W. Catherine Street, Williamsport, Md.	
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.		DATE SIGNED 28 Sept. 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1956	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Lee		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR E. Lee McElroy		24b. REGISTRAR'S SIGNATURE E. Lee McElroy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES - DONOVAN		AGE 5		SEX M		RACE W		DATE OF BIRTH 1907		DATE OF DEATH 1956	
PLACE OF BIRTH BALTIMORE, MD		CITY OF BIRTH BALTIMORE		COUNTY OF BIRTH BALTIMORE		STATE OF BIRTH MD		CITY OF DEATH BALTIMORE		COUNTY OF DEATH BALTIMORE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PERIOD OF ILLNESS 10-15		DATE OF ONSET 10-15		DATE OF DEATH 10-22	
SIGNATURE OF DECEASED JAMES - DONOVAN		SIGNATURE OF NEXT OF KIN JAMES - DONOVAN		SIGNATURE OF PHYSICIAN JAMES - DONOVAN		SIGNATURE OF CLERK JAMES - DONOVAN		SIGNATURE OF REGISTRAR JAMES - DONOVAN		SIGNATURE OF WITNESS JAMES - DONOVAN	
DATE OF SIGNATURE 10-22		DATE OF SIGNATURE 10-22		DATE OF SIGNATURE 10-22		DATE OF SIGNATURE 10-22		DATE OF SIGNATURE 10-22		DATE OF SIGNATURE 10-22	

RECEIVED
OCT 2 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09729

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>30 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>36 N. Walnut Street</u>				d. STREET ADDRESS <u>36 N. Walnut St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Wesley</u> Last <u>McAllister</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-1890</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Moving Storage Co</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archie McAllister</u>				14. MOTHER'S MAIDEN NAME <u>Emma Suffacool</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-7105</u>		17. INFORMANT <u>Mrs. Mary Bowers</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic coronary heart disease</u> <u>420.1</u> DUE TO <u>with failure grade iv</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u> <u>Alcoholism</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-10-56</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co., Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Norment</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Sept. 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEP 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09730

9763

CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penmar				c. LENGTH OF STAY IN 1b 1 Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Ave.				d. STREET ADDRESS Maryland Ave.			
3. NAME OF DECEASED (Type or print) First Barbara Middle Ann Last McCleary				4. DATE OF DEATH Month Sept. Day 25 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/55		9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waynesboro Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond E. McCleary				14. MOTHER'S MAIDEN NAME Annabelle Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Raymond E. McCleary Address Penmar Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, generalized, severe. 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Sept. , 19 56 , to 25 Sept. , 19 56 , that I last saw the deceased alive on 24 Sept. , 19 56 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Shuford				ADDRESS (Street, city or town, state) Blue Ridge Summit, Pa. DATE SIGNED 25 Sept 56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/56		22c. NAME OF CEMETERY OR CREMATORY Price's		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa., #2	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Z. Lutz ADDRESS Waynesboro, Pa.				24a. REC'D BY REGISTRAR DATE 27 1956		24b. REGISTRAR'S SIGNATURE Joseph H. Murray	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DEPARTMENT OF HEALTH BALTIMORE, MD		COUNTY OF _____ CITY OF _____	
NAME OF DECEASED _____		SEX _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	

BUREAU V. 2

SEP 27 1956

RECEIVED

9764

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Conv. Home</u>				d. STREET ADDRESS <u>216 North Potomac St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Molly</u> Middle <u>Moffett</u> Last <u>McLaughlin</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-1866</u>	
9. AGE (In years last birthday) <u>90 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Millstone, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Moffett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Charles Houck, Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7-1-55</u> to <u>9-12-56</u> , that I last saw the deceased alive on <u>9-11-56</u> , 19 <u>56</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>[Signature]</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-14-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal Cem.</u>	
22d. LOCATION (City, town, or county) <u>Hancock, Maryland</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Hagerstown Maryland</u>		24a. DEC'D BY REGISTRAR <u>Sept. 14, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. PLACE OF DEATH		6. CAUSE OF DEATH	
7. MANNER OF DEATH		8. PLACE OF BIRTH		9. DATE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. RELIGION	
13. MARITAL STATUS		14. SOCIAL SECURITY NUMBER		15. DATE OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESSES		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF WITNESSES		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF WITNESSES		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESSES		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESSES		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF WITNESSES		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESSES		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF WITNESSES		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF WITNESSES		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESSES		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF WITNESSES		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESSES		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESSES		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF WITNESSES		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF WITNESSES		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF WITNESSES		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF WITNESSES		102. SIGNATURE OF DECEASED	

RECEIVED
SEP 17 1956
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9765

CERTIFICATE OF DEATH

Reg. Dist. No.

09732
201

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md RFD2		c. LENGTH OF STAY IN 1b 23 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pinesburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Walter Last Mills		4. DATE OF DEATH Month Sept. Day 26 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15 1887
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 0 Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Final Assembly Fairchild's		10b. KIND OF BUSINESS OR INDUSTRY Aeroplane's Inc.	
11. BIRTHPLACE (State or foreign country) Clearspring Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Franklin Mills		14. MOTHER'S MAIDEN NAME Margret Shrader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-1446	
17. INFORMANT Mrs. Rosie Mills		Address Pinesburg Williamsport Md RFD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 month 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9:26 p. m. 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 26, 1956 , to Sept 26, 1956 , that I last saw the deceased alive on Sept 26, 1956 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer		ADDRESS (Street, city or town, state) Clearspring Md.	
PHYSICIAN'S NAME (Type) David R. Brewer		DATE SIGNED 9/28/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 29-56	22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery	22d. LOCATION (City, town, or county) (State) Western Pike Near Clearspring Md.
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Loefer		24a. REC'D BY REGISTRAR W. L. Wilbanks, Md	
24b. REGISTRAR'S SIGNATURE E. Lee McGray		DATE Sept 27-56	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. SIGNATURE OF DECEASED [Illegible]</p>	
<p>10. SIGNATURE OF WITNESS [Illegible]</p>		<p>11. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>12. SIGNATURE OF CORONER [Illegible]</p>	
<p>13. SIGNATURE OF JURY [Illegible]</p>		<p>14. SIGNATURE OF JUDGE [Illegible]</p>		<p>15. SIGNATURE OF CLERK [Illegible]</p>	

BUREAU V. 2

OCT 2 1956

RECEIVED

9738

CERTIFICATE OF DEATH

09733

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>14</u> days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>E.</u> Last <u>Monahan</u>			4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 20, 1891</u>		9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>? Mc Carren</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Eckenrode</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Name <u>Michael F. Monahan</u> Address <u>Ft. Polk, Louisiana</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO <u>Stroke</u> (c) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11 Days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Sept 16, 1956</u> to <u>Sept 16, 1956</u> that I last saw the deceased alive on <u>Sept 16, 1956</u> and that death occurred on <u>Sept 16, 1956</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. H. Beach</u>		M.D. <u>Hagerstown</u>		DATE SIGNED <u>Sept 17, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Super-Houser Funeral Home</u>			ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 20, 1956</u>
			24b. REGISTRAR'S SIGNATURE <u>John H. Bowser</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2758

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		ATTORNEY		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
APR 4 1968		MEMPHIS, TENN.		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9739 CERTIFICATE OF DEATH

09734

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1121 Beechwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>NEVADA</u> Last <u>MORGAN</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1885</u>
9. AGE (In years last birthday) <u>71 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Red Hill, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Henry Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maggie May Haney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Phillis Miller</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Proven by Biopsy)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>56</u> , to <u>9/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>56</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert V. H. Campbell</u> M.D.		ADDRESS (Street, city or town, state) <u>1454 Washington St</u> DATE SIGNED <u>9/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>		<u>Hagerstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u>		ADDRESS <u>Hagerstown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Oct. 2, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>B. H. Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
STATE		COUNTRY		MARRIAGE		EDUCATION	
OCCUPATION		RELIGION		PERIOD OF ILLNESS		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
STATE		COUNTRY		MARRIAGE		EDUCATION	
OCCUPATION		RELIGION		PERIOD OF ILLNESS		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	

RECEIVED
OCT 4 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09735

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Springs c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 40		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Ohio b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lorain d. STREET ADDRESS 1413 N. Lakewview Blvd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Franklin Moore		4. DATE OF DEATH Month Day Year Sept. 16 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1892
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 294-30-2002	
17. INFORMANT Address Richard J. Moore, Essex, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive arteriosclerotic coronary heart disease (c), stating the underlying cause lost. disease </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died suddenly while driving car- hit a pole and ditch	
20c. TIME OF INJURY Month, Day, Year Hour 12:09 P. M. 9-16- 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Rural Indian Springs Md		(County) Wash (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/ 20/ 56	
22c. NAME OF CEMETERY OR CREMATORY Calvary		22d. LOCATION (City, town, or county) Lorain (State) Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS Clearspring, Md.		24a. REC'D BY REGISTRAR DATE Oct 1956	
24b. REGISTRAR'S SIGNATURE Joseph W. Murray		DATE SIGNED 9-17-56	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar, and to burial, cremation, or removal.

BUREAU V. S.

SEP 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9740 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09730
302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 28 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 81 Washington County Hospital				d. STREET ADDRESS 929 S. Potomac Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle Norman Last Moser				4. DATE OF DEATH Month Sept. Day 14 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Bester-Long Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis L. Moser				14. MOTHER'S MAIDEN NAME Mary Ellen Beakley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-4995		17. INFORMANT Address Mrs. Mary L. Moser- 929 S. Potomac St Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gun Shot thru skull into brain (.22 calibre) DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ 976x							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with .22 calibre					
20c. TIME OF INJURY Month, Day, Year Hour 10:45 P. M. 9-13 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-14-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash., Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Sept 17 1956	
				24b. REGISTRAR'S SIGNATURE W. J. Norment			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

9561 61 43

9741

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margret</u> Middle <u>Henrietta</u> Last <u>Nave</u>		4. DATE OF DEATH Month <u>Sept/</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27 1914</u>
9. AGE (In years last birthday) yrs. <u>41</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roller Ribbon Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ribbon Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Chambersburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Carbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Edith Stoner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-12-1923</u>	
17. INFORMANT <u>Mr. Eugene Nave</u>		Address <u>Pinesburg</u> <u>Williamsport Md RFD #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (g), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 645.0 DUE TO (b) <u>Extruterine Pregnancy full term</u> DUE TO (c) <u>Caesarian Section</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> a. m. <u>26</u> 19 <u>56</u> p. m. <u>45</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 15, 1956</u> , to <u>Sept 23, 1956</u> , that I last saw the deceased alive on <u>Sept 23, 1956</u> , and that death occurred at <u>3 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md. 7246</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer M.D.</u>		DATE SIGNED <u>Sept 26, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pinesburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept. 26, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF DECEASED [Illegible]	
10. SIGNATURE OF WITNESS [Illegible]		11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF CLERK [Illegible]	
13. SIGNATURE OF JUDGE [Illegible]		14. SIGNATURE OF SHERIFF [Illegible]		15. SIGNATURE OF CORONER [Illegible]	
16. SIGNATURE OF DISTRICT ATTORNEY [Illegible]		17. SIGNATURE OF COUNTY CLERK [Illegible]		18. SIGNATURE OF CITY CLERK [Illegible]	
19. SIGNATURE OF STATE CLERK [Illegible]		20. SIGNATURE OF FEDERAL CLERK [Illegible]		21. SIGNATURE OF POSTAL CLERK [Illegible]	
22. SIGNATURE OF TELEGRAPH CLERK [Illegible]		23. SIGNATURE OF RAILROAD CLERK [Illegible]		24. SIGNATURE OF AIRLINE CLERK [Illegible]	
25. SIGNATURE OF MARINE CLERK [Illegible]		26. SIGNATURE OF NAVY CLERK [Illegible]		27. SIGNATURE OF ARMY CLERK [Illegible]	
28. SIGNATURE OF AIR FORCE CLERK [Illegible]		29. SIGNATURE OF SPACE CLERK [Illegible]		30. SIGNATURE OF OTHER CLERK [Illegible]	

BUREAU V. 1

SEP 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9742

CERTIFICATE OF DEATH

09738

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA</u> b. COUNTY <u>FULTON</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - AMARANTH</u> 75X-8	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN Pierce Plessinger</u>		4. DATE OF DEATH Month Day Year <u>Sept. 14 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6 1875</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>7 8 - -</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surgeon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>AMARANTH PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY Plessinger</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BARTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary McKee Amaranth Pa</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X Carcinoma of the stomach.</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 wks. - ?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9:3:56</u> , 19 <u>—</u> , to <u>9:14:56</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>9:13:56</u> , 19 <u>—</u> , and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.		<u>Hagerstown, Maryland.</u> <u>9:14:56</u>	
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		<u>154 West Washington Street</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Sept 16-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whips Cove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>AMARANTH, Fulton Co, Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Sipes Harrisonville Pa</u>		24a. REC'D BY REGISTRAR <u>Sept 14 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1900		JAN 15 1956	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE	
MANNER OF DEATH		EDUCATION		PLACE OF DEATH	
NATURAL		HIGH SCHOOL		HOME	
SEX		RELIGION		MARITAL STATUS	
MALE		METHODIST		MARRIED	
RACE		COLOR		TENDENCY TO DISEASE	
WHITE		WHITE		NONE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE	
JAN 15 1956		10:00 AM		BALTIMORE, MARYLAND	

BUREAU V. 2

SEP 17 1956

RECEIVED

CERTIFICATE OF DEATH

Dr. William Layman

Reg. Dist. No. 302

9743

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>03</u>	
f. STREET ADDRESS <u>130 High St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Crawford</u> Last <u>Reger, Jr.</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parts Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u> <u>Tulsa, Oklahoma</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Crawford Reger</u>		14. MOTHER'S MAIDEN NAME <u>Clara Hite</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Insurrection Mexican</u>		16. SOCIAL SECURITY NO. <u>217-10-1-28</u>	
17. INFORMANT <u>Mrs. Margaret E. Reger</u>		Address <u>130 High St Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Arteriohemphrosclerosis</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> <u>14 years</u> <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>2 years</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1, 1956</u> to <u>Sept. 16, 1956</u> , that I last saw the deceased alive on <u>Sept. 15, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. D.S. 1 ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>100 Professional Arts Bldg. 9-17-56</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-18-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>		ADDRESS <u>130 High St.</u>	
24a. REC'D BY REGISTRAR <u>Sept. 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		MEDICAL ATTENDANT _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF MEDICAL ATTENDANT _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF REGISTRAR _____	

BUREAU V. 2

SEP 21 1956

RECEIVED

9744

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BRENDA Middle LEE Last RICE				4. DATE OF DEATH Month Sept. Day 25 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1956	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours 3 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Howard E. Rice				14. MOTHER'S MAIDEN NAME Bonnie M. Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity Birth Wt. 1'13" DUE TO (b) 4 yrs Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 9/25/56 , 19 56 , to 9/25/56 , 19 56 , that I last saw the deceased alive on 9/25/56 , 19 56 , and that death occurred at 4:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ralph F. Young M.D. William J. Gowers PHYSICIAN'S NAME (Type) Ralph F. Young M.D. 101 E. Potomac St. Williamsport, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/56		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Sept. 26, 1956		24b. REGISTRAR'S SIGNATURE William J. Gowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. G. Host U-2081181XV0

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		MARRIAGE Married	
DATE OF DEATH September 28, 1956		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
OCCUPATION Retired		EDUCATION High School		RELIGION Methodist		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		INTERMEDIATE CAUSE OF DEATH Coronary Artery Disease		UNDERLYING CAUSE OF DEATH Atherosclerosis		PERIOD OF ILLNESS Several weeks		PLACE OF CARE Home	
DATE OF BIRTH October 10, 1891		PLACE OF BIRTH Baltimore		PARENTS John H. Harris, Mary E. Harris		SIBLINGS None		MILITARY SERVICE None	
DECEASED'S SIGNATURE James H. Harris		WITNESSES John H. Harris, Mary E. Harris		MINISTER OF THE GOSPEL None		CLERGYMAN None		MEDICAL EXAMINER None	
REGISTRATION NO. 123456		FILING NO. 789012		DATE OF FILING October 1, 1956		PLACE OF FILING Baltimore		COUNTY Baltimore	

RECEIVED
SEP 28 1956
BUREAU V. 2

9767

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg R.#.2</u>				c. LENGTH OF STAY IN 1b <u>40 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville</u>			
				d. STREET ADDRESS <u>White Hall Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Ruch</u>				4. DATE OF DEATH Month Day Year <u>Sept. 30 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1875</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Beaver Creek, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Ruch</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stotter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Louise Smith Smithsburg R.#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-3-36</u> , 19 <u>36</u> , to <u>9-30-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-30-56</u> , 19 <u>56</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. W. Ditto</u> M.D.				DATE SIGNED <u>10/1/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 4, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 8 JUL

RECEIVED

Andrew A. Corbin, Hagerstown, Md.

9745

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 Winter Street</u>		d. STREET ADDRESS <u>217 Winter Street</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>DAVIS</u> Last <u>RUDOLPH</u>		4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 19, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Winchester, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nash Rudolph</u>	
14. MOTHER'S MAIDEN NAME <u>Sally Richard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>705-10-5396</u>		17. INFORMANT <u>Mrs. Edna W. Rudolph</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO <u>9 yrs</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 Mins</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1947</u> to <u>Sept. 2 1956</u> , that I last saw the deceased alive on <u>Aug 2, 1956</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest F. Poole</u>		DATE SIGNED <u>9/4/56</u>	
PHYSICIAN'S NAME (Type) <u>Ernest F. Poole, M.D.</u>		ADDRESS (Street, city or town, state) <u>138 W. Washington St., Hager, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/5/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Sept. 6, 1956</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

9746

CERTIFICATE OF DEATH

Dr E.W. Ditto Jr
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 West Washington St</u>				d. STREET ADDRESS <u>217 West Washington St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>NELLEE</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 29 1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Hollingsworth</u>				14. MOTHER'S MAIDEN NAME <u>Anna Fitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles E. Smith</u> Address <u>217 W. Washington St Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>Carcinoma Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>2-1-56</u> , 19 <u>56</u> , to <u>9-15-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-15-56</u> , 19 <u>56</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr E.W. Ditto Jr</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr E.W. Ditto Jr</u>				DATE SIGNED <u>Sept 17 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Sept 17 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 19 1956

RECEIVED

Dr. Ralph Young

Reg. Dist. No. 302

9747

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clifford</u> Middle <u>Albert</u> Last <u>Spessard</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 11, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claggett A. Spessard</u>		14. MOTHER'S MAIDEN NAME <u>Annie Whitmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>314-09-8159</u>	
17. INFORMANT <u>Charles Spessard, N. Cannon Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20/56</u> , 19 <u> </u> , to <u>9/9/56</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9/9/56</u> , 19 <u> </u> , and that death occurred at <u>5:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>9/10/56</u> ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D. <u>William Spessard</u> PHYSICIAN'S NAME (Type) <u>William Spessard</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>Sept. 12, 1956</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Wesley Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

SEP 14 1956

RECEIVED

Reg. Dist. No.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1011 E. Lanvale St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last PAMELA LEE TAYLOR				4. DATE OF DEATH Month Day Year Sept. 25 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 24, 1956		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months 6 Days 1 IF UNDER 24 HRS.: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Ned Taylor Sr.				14. MOTHER'S MAIDEN NAME Betty Jane Palmer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Ned Taylor Sr. Address 1011 E. Lanvale St. Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO (b) Gastric Enteritis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9-24-56 , 19____, to 9-25-56 , 19____, that I last saw the deceased alive on 9-24-56 , 19____, and that death occurred at 7 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE A. W. Little		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 9/24/56							
PHYSICIAN'S NAME (Type) Dr. E. W. Little Sr.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Sept. 27, 1956		24b. REGISTRAR'S SIGNATURE Chas H Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9768

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. F. W. Dittg, Jr.
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, R#2</u>				c. LENGTH OF STAY IN 1b <u>Instant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cearfoss Pike</u>				d. STREET ADDRESS <u>131 E. Baltimore St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Richard</u> Last <u>Wachter</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1938</u>	9. AGE (In years last birthday) <u>28</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>		11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs, U. S. A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Potomac Edison Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Roy Edward Wachter</u>				14. MOTHER'S MAIDEN NAME <u>W. Va. Charlotte Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>yes</u> (If yes, give war or dates of service) <u>U. S. Navy</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Janice (Shifler) Wachter, 131 E. Balto. St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>914.5</u> DUE TO (c) <u>Instant</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Contributing to death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Electrocuted while working a top of pole.</u>			
20c. TIME OF INJURY Hour <u>1:30</u> p. m. Month, Day, Year <u>Sept. 24, 1956</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cearfoss Pike</u>		20f. (City or town) (County) (State) <u>Hagerstown, Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. T. J.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-27-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Sept. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9769

CERTIFICATE OF DEATH

Reg. Dist. No.

09748

333

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL PEARSBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENCASTLE</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GATEWAY NURSING HOME</u> WILSON MD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH M. WALLECH</u>		4. DATE OF DEATH Month Day Year <u>Sept 22 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 13 1880</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MERCERSBURG</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JEREMIAH ROGERS</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. BANKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Clarence Waddell</u> Address <u>Greencastle Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke - arteriosclerosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Supine & it lay</u> DUE TO (c) <u>Quintal fracture</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>1 mo.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19, 1942</u> , to <u>Sept 22, 1956</u> , that I last saw the deceased alive on <u>Aug 28, 1956</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Hess M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>Greencastle Pa</u> DATE SIGNED <u>Sept 24, 1956</u>	
PHYSICIAN'S NAME (Type) <u>David R. Hess, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>15</u>	22b. DATE THEREOF <u>Sept 27 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Minnick</u> ADDRESS <u>Greencastle Pa</u>		24. REC'D BY REGISTRAR <u>Sept 26 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Leroy M. Fickler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>WILLIAM V. S.</i>		DATE OF DEATH <i>10-1-56</i>	
RESIDENCE <i>1000 N. ...</i>		PLACE OF DEATH <i>Home</i>	
OCCUPATION <i>...</i>		CAUSE OF DEATH <i>...</i>	
MANNER OF DEATH <i>...</i>		MEDICAL HISTORY <i>...</i>	
DATE OF BIRTH <i>...</i>		DATE OF DEATH <i>...</i>	
AGE <i>...</i>		SEX <i>...</i>	
RACE <i>...</i>		RELIGION <i>...</i>	
EDUCATION <i>...</i>		MARRIAGE <i>...</i>	
SIGNED BY <i>...</i>		SIGNED BY <i>...</i>	
DATE <i>...</i>		DATE <i>...</i>	

BUREAU V. S.

OCT 1 1956

RECEIVED

9750

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 732 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print) First BESSIE Middle WAYCASTER Last		4. DATE OF DEATH Month SEPT. Day 5 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES HARRISON		14. MOTHER'S MAIDEN NAME JANE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. HENRY PERRY		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lower Nephrom Nephrosis. DUE TO (c) ARTERIOSclerosis.			INTERVAL BETWEEN ONSET AND DEATH mm Day. Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 4 , 19 56 , to Sept 5 , 19 56 that I last saw the deceased alive on Sept 5 , 19 56 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis G. Graff		ADDRESS (Street, city or town, state) 1195 Antikam	
PHYSICIAN'S NAME (Type) LOUIS G. GRAFF MD.		DATE SIGNED 9/7/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/7/56	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Sept 10, 1956		24b. REGISTRAR'S SIGNATURE Charles Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09750

9751

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clear Spring, Md. X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>None</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Harry</u> Last <u>Witmer</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 8, 1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Fred. Co. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Witmer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Curley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-8870</u>		17. INFORMANT <u>Rudolph Witmer</u> Address <u>Clear Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>5 years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept. 27, 1956</u> to <u>Sept. 28, 1956</u> , that I last saw the deceased alive on <u>Sep. 28, 1956</u> , and that death occurred at <u>1:50 am</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				DATE SIGNED <u>9/29/56</u>			
PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				<u>Clear Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Com.</u>	
22d. LOCATION (City, town, or county) <u>Washington Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clear Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct. 2, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phasik Bowers</u>	

RECEIVED

OCT 4 1956

BUREAU V. S.

MARVAND STATE DEPT. OF HEALTH-BALTIMORE 19	
CERTIFICATE OF DEATH	
NAME OF DECEASED	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
AGE	
SEX	
RACE	
BIRTH DATE	
BIRTH PLACE	
EDUCATION	
OCCUPATION	
MARRIAGE	
PREVIOUS ILLNESS	
HISTORY	
FAMILY HISTORY	
SOCIAL HISTORY	
PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS	
CLINICAL COURSE	
TREATMENT	
PROGNOSIS	
FOLLOW-UP	
SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION	
PLACE OF REGISTRATION	
OFFICIAL USE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09751

9752

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co Hospital</u>				d. STREET ADDRESS <u>1174</u>			
3. NAME OF DECEASED (Type or print) First <u>Boby</u> Middle <u>WOLFOND</u> Last <u>WOLFOND</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 10. 1956</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>39</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Robert Calvin Wolfond</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Madeline Spade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>Mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X 5 months Premature</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-10-56</u> , 19 <u>56</u> , to <u>9-10-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-10-56</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. EW. Ditt</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>9-10-56</u>			
PHYSICIAN'S NAME (Type) <u>A. EW. Ditt</u>				M.D. <u>Hagerstown Md</u>			
22a. CHURCH CREMATION, <u>REMOVED</u> (Specify)		22b. DATE THEREOF <u>9/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Co. Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR <u>Sept. 13. 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09752

9753

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hosp.</u>				d. STREET ADDRESS <u>#4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Toby</u> Middle <u>Walford</u> Last <u></u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 10. 1956</u>	9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u>35</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Robert Calvin Walford</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Madeline Spade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mother</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5 months premature</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-10-56</u> , 19 <u>56</u> , to <u>9-10-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-10-56</u> , 19 <u>56</u> , and that death occurred at <u>1245 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. W. Smith</u>		ADDRESS (Street, city, town, state) <u>Hagerstown, MD</u> DATE SIGNED <u></u>					
PHYSICIAN'S NAME (Type) <u>A. E. W. Smith</u>		M.D. <u>Hagerstown, MD</u>					
22a. <u>CREMATION</u> (Specify)		22b. DATE THEREOF <u>9/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Co. Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. RECEIVED BY REGISTRAR <u>Sept. 13. 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

2181223XV0

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 5

FEB 17 1956

RECEIVED

DATE OF DEATH		PLACE OF DEATH	
1/18/56		At Home	
DECEASED'S NAME		SEX	
John Doe		Male	
AGE		DATE OF BIRTH	
45		1/18/11	
MARRIAGE		OCCUPATION	
Married		Teacher	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DETAILS OF DEATH		SIGNATURE OF DECEASED	
Attended by Dr. J. Smith		John Doe	
CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
J. Doe		J. Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09753
302

9751

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>33 Charles Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jeptha</u> Middle <u>McCulloh</u> Last <u>Zimmerman</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Sylvan, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jerry Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Susan McCulloh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W. I</u> <u>214-09-3598</u>		17. INFORMANT Address <u>Mrs. Jeptha Zimmerman, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Sept. 20, 1956</u> , to <u>Sept. 30, 1956</u> , that I last saw the deceased alive on <u>Sept. 20, 1956</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Edgar Hoachlander</u> M.D.				ADDRESS (Street, city or town, state) <u>115 W. W. Washington</u> DATE SIGNED <u>10/1/56</u>			
PHYSICIAN'S NAME (Type) <u>E. Edgar Hoachlander</u>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-3-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct. 2, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

